STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005034	A. BUILDING: _____ B. WING _____	02/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA UNIVERSITY HEALTH WHITE MEMORIAL HC	720 SOUTH SIXTH ST MONTICELLO, IN 47960

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS HFAP Surveyor: 33212 Facility Number: 005034 Type of Survey: State Licensure Off Site Healthcare Facilities Accreditation Program Survey Date of HFAP On Site Survey - Hospital full survey 02/01-02/2016 Date of ISDH off site review - 6/27/2016 Based on review of the February 2, 2016 HFAP Accreditation Survey Report, it has been determined that Indiana University Health White Memorial Hospital, Inc. meets the requirements for Hospital Licensure in Indiana for 2016.	S 000		